

Inadequate 

# Derbyshire Healthcare NHS Foundation Trust

## Forensic inpatient/secure wards

### Quality Report

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### Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RXM04	Kedleston Unit	Curzon ward	DE22 3LZ
RXM04	Kedleston Unit	Scarsdale ward	DE22 3LZ

This report describes our judgement of the quality of care provided within this core service by Derbyshire NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.


Where applicable, we have reported on each core service provided by Derbyshire NHS Foundation Trust and these are brought together to inform our overall judgement of Derbyshire NHS Foundation Trust.

# Summary of findings

## Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

### Overall rating for the service

Inadequate 

Are services safe?

Inadequate 

Are services effective?

Inadequate 

Are services caring?

Requires improvement 

Are services responsive?

Good 

Are services well-led?

Inadequate 

### **Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards**

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

# Summary of findings

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# Summary of findings

## Overall summary

We rated forensic inpatient/secure ward as inadequate because:

- Patient safety was compromised by the lack of staff training in key aspects of care such as basic life support and intermediate life support.
- Monitoring of patients' physical health following restrictive interventions and/or rapid tranquillisation was inconsistent.
- Environmental risks identified had not been addressed despite action plans indicating mitigating actions to be taken.
- We found that care plans were not holistic, personalised or recovery-focused. Patients input into their care plans were not evident. Provision of physical health assessments for patients on admission to the service was inconsistent.
- Patients were not provided with the opportunity to create advance decisions detailing their preferences for care and treatment.
- The seclusion rooms did not comply with the guidance set out in the Mental Health Act (1983) or the Code of practice (2015).

However:

- Nursing staff had undertaken nursing risk assessments called functional assessment of the care environment

(FACE) of patients upon admission. Nurses had updated these risk assessments regularly to reflect any changes in risk. FACE risk assessments are not as detailed as HCR20v3 risk assessments.

- Staff knew to report and record all risk incidents, and all near misses, and did this consistently. They were open and transparent and explained to patients when things went wrong.
- Patients had wellness recovery action plans (WRAP) which were personalised and staff had created these in collaboration with the patient.
- The service was participating in the Quality Network for Forensic Mental Health Services. They were also engaged in Commissioning for Quality and Innovation (CQUIN) towards the provision of a recovery college and reducing the use of restrictive interventions.
- Bed occupancy was low; the average length of stay for patients was short and readmissions within 90 days were low.
- Staff were responsive to patients' needs and they were supportive. Patients told us staff were kind and caring.
- Staff morale was good and they were very positive about the leadership by the new unit manager. They spoke very positively about their team; they were proud of their team and were supportive of one and other.

# Summary of findings

## The five questions we ask about the service and what we found

### Are services safe?

We rated safe as inadequate because:

- Seclusion facilities did not comply with standards set out in the Mental Health Act (1983) or the Code of Practice (2015). Reporting of the use of seclusion was inaccurate and reflected lower use of seclusion than was actually taking place.
- Records did not show that patients subject to restraint, seclusion or rapid tranquillisation medicine had been physically monitored by staff following any of these interventions.
- Bank nursing staff were not always competent and up-to-date with 'control and restraint' training for managing violence and aggression.
- Low numbers of staff were up-to-date with basic life support and intermediate life support training.
- Managers had not addressed all environmental risks, including ligature risks, identified through annual audit.
- The clinic room was cramped and cluttered. Emergency equipment was stored in a large, locked trolley; the trolley would be clumsy and difficult to manoeuvre through the airlocks on to the wards.
- Soft furnishings on Curzon ward were dirty, worn and threadbare on the arms of chairs. Fabric was torn in some places.
- Staff had not fully considered security in the secure garden area in terms of unnecessary items, such as bins, which were not subject to security procedures.
- Gender ratios of staff on some shifts meant that patients would have to wait to have their needs met by a member of staff of the appropriate gender.
- Completion of the 20 item historical clinical risk version 3 (HCR20v3) risk assessments was inconsistent; some patients had not been screened at all. HCR-20V3 is a comprehensive set of professional guidelines for the assessment and management of violence risk.

However:

- Staff knew to report and record all risk incidents and all near misses. They were open and transparent and explained to patients when things went wrong. Staff had apologised to a patient when a confidential letter was sent to the incorrect address.

Inadequate



# Summary of findings

- Staff received feedback from investigation of incidents, both internal and external to the service, at monthly staff meetings, in clinical supervision and through the trust's 'blue light' system on the trust intranet. The 'blue light' system was an electronic system that sent an alert to all staff in the form of an email. The 'blue light' email would contain information about whatever the issue was along with actions staff must take in the future consequently.

## Are services effective?

We rated effective as Inadequate because:

- Doctors had not consistently provided all patients with physical health assessments on admission. Doctors told us that patients attended the local GP for annual physical health checks but we were unable to find any evidence of this having taken place in any patients' care records.
- Patients' care plans were not personalised, holistic or recovery-oriented.
- Doctors were not requesting second opinion approved doctors (SOAD) in a timely manner.
- Patients did not have positive behaviour support plans as recommended by the Mental Health Act Code of Practice (2015), 'Positive and Safe' (DH 2014) and national institute of health and care excellence (NICE) guideline NG10 (2015).
- Mental Health Act documentation was chaotically filed on the ward. It took some considerable time and effort to track down all relevant parts of the documentation. This is important because staff need to know under which legal authority they are providing care and treatment.
- Staff had not undertaken any formal assessments of mental capacity for any patients. We found evidence that staff had not undertaken a mental capacity assessment of a patient who was having medicines administered on the authorisation of a T2 (section 58 consent to treatment certificate) prior to signing to say he had mental capacity to agree to self-administer medicines.
- Staff understanding of mental capacity was poor.

However:

- Patients had wellness recovery action plans (WRAP) which were personalised and had been created in collaboration with the patient.
- Patients had their rights under Section 132 presented to them on admission and every three months thereafter. Patients could access advocacy services if they wished.

**Inadequate**



# Summary of findings

## Are services caring?

We rated caring as requires improvement because:

- Patients' care records did not demonstrate patients being actively involved in care planning, nor of them consistently offered a copy of care plans.
- Patients were not involved in service development. They were not involved in staff recruitment processes.
- Patients did not have advance decisions in place

However:

- Staff were responsive to patients' needs and they were supportive. Patients told us staff were kind and caring. Patient led assessments of the care environment (PLACE) scores relating to privacy, dignity and wellbeing were above the England average.
- Patients were involved in assessing their own risks in collaboration with the multidisciplinary team (MDT) in MDT meetings. Patients had individualised occupational therapy schedules of 'meaningful activity'.
- Staff facilitated morning planning meetings where patients negotiated access to Section 17 leave with staff and each other.

Staff offered families and carers the opportunity to be involved in care programme approach meetings.

Requires improvement



## Are services responsive to people's needs?

We rated responsive as good because:

- The wards were fully accessible for people with physical disability. Adapted bathrooms were available on both wards. Patients with particular dietary requirements had their needs met.
- Patients could access spiritual support from local spiritual leaders if they wished to do so. Staff could contact the spiritual leader and arrange for visits. There was no multi-faith room available in the unit for patients to use.
- Patients had individualised meaningful activity schedules. They could access outside space in the secure garden throughout the day.
- Staff received feedback about outcomes from complaints investigations in supervision and in monthly staff meetings. If it was a trust wide issue, there would be a 'blue-light' alert sent round to all trust staff via email.
- Bed occupancy figures were low; average length of stay was short, and re-admissions to the service within 90 days were low.

However:

Good



# Summary of findings

- Managers had not ensured that information leaflets about the service, about advocacy services, about the Care Quality Commission, and about the complaints, procedure was readily available on wards.
- Patients on Curzon ward could not have 24-hour access to their kitchen due to the potential ligature risks present.
- Patients on Curzon ward did not have keys to their rooms.
- Staff did not provide structured activities as an option for patients in evenings and weekends.

## Are services well-led?

We rated well-led as inadequate because:

- Governance process had failed to identify or protect people from unsafe care
- Staff did not know the trust's vision or values.
- Ward systems were not effective in ensuring that staff received mandatory training. Staff compliance with key training such as basic life support, intermediate life support and medicines management was low and did not meet Trust expected targets'.
- Staff did not routinely monitor patients' physical health following the use of restrictive interventions and/or rapid tranquillisation.
- Sickness absence rates were 10%, which is above the national average of 4.4%. This figure is attributed to long term sickness of two members of staff.
- There was a disconnect between the aspirations of the trust in reducing the use of restrictive interventions and what was actually taking place on the wards. The trust policy governing the use of seclusion was inaccurate. There was under-reporting of the use of seclusion so it would not be possible for the trust to be working on accurate data towards achieving their aspiration.

However:

- Staff maximised shift time on direct care activities. Risk incidents and near misses were reported appropriately. Incident forms completed by staff demonstrated learning following risk incidents.
- The unit manager had sufficient authority and adequate administrative support. Staff had the ability to submit items to the trust risk register.
- There were no ongoing bullying and harassment cases. Staff knew how to use the whistle-blowing process. They told us they felt able to raise concerns without fear of victimisation. Their

**Inadequate**





# Summary of findings

morale was good despite the challenges and they were very positive about the new unit manager and believed that he would bring about positive changes to the service. They spoke very positively about their team; they were proud of their team and were supportive of one and other. Staff were open and honest and explained to patients if something went wrong. They could give feedback about the service in staff meetings; in addition, they could also go directly to the unit manager who welcomed their input.

- The service was participating in the Quality Network for Forensic Mental Health Services. They were also engaged in Commissioning for Quality and Innovation (CQUIN) towards the provision of a recovery college, and reducing the use of restrictive interventions.

# Summary of findings

## Information about the service

The Kedleston Low Secure Unit provides a gender-specific low secure service for male patients.

It delivers intensive, comprehensive, multidisciplinary treatments and care by qualified staff and healthcare assistants.

The service provides for men aged 18 years and above who suffer from a mental disorder, and were detained under the Mental Health Act 1983. They require treatment in a specialist low secure service, and usually have complex and challenging forensic and mental health needs.

There are two wards at the Kedleston Unit: Curzon is the admission and assessment ward, and Scarsdale is the rehabilitation ward. Curzon ward has eight beds and Scarsdale ward has 12 beds; bedrooms are not en-suite on either ward and patients have access to shared bathroom facilities.

We undertook an unannounced Mental Health Act review in January 2016. Issues highlighted during that inspection related to;

- lack of patient involvement in care planning;
- no provision of community meetings for patients;
- an absence of information relating to complaints procedures available on the wards;
- blanket restrictions on Curzon ward;
- poor administration of cancelled Section 17 leave documentation; and
- seclusion rooms not complying with standards laid down in the Mental Health Act Code of Practice (2015).

Cancelled Section 17 leave documentation was being appropriately administered. However, none of the remaining issues had been resolved.

## Our inspection team

Our inspection team was led by:

Chair: Vanessa Ford, Director of Nursing Standards and Governance, West London Mental Health

NHS Trust.

Head of Hospital Inspections, CQC: James Mullins.

The location inspection team comprised one CQC inspector, one expert by experience and three specialist advisors. The specialist advisors were a consultant forensic psychiatrist, a senior nurse and a Mental Health Act reviewer.

## Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

## How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?

- Is it responsive to people's needs?
- Is it well led?

Before the inspection visit, we reviewed information that we held about these services, and asked a range of other organisations for information.

During the inspection visit, the inspection team:

# Summary of findings

- visited two wards at the hospital site and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with nine patients who were using the service
- spoke with the manager for each of the wards
- spoke with 17 other staff members including doctors, nursing staff, a psychologist, a pharmacist and occupational therapists
- interviewed the lead violence and aggression trainer in the trust
- Interviewed the Mental Health Act lead in the trust
- Interviewed the Mental Capacity Act lead in the trust
- attended and observed one hand-over meeting and two multi-disciplinary meetings
- attended and observed three therapy groups
- looked at 19 treatment records of patients
- carried out a specific check of the medicines management on two wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

## What people who use the provider's services say

We spoke to nine patients. They gave mixed views about the service. Some patients gave positive comments about the staff, food, and environment. For example, one patient said it was the occupational therapists that had helped him the most. Other patients praised the psychologists.

Some patients expressed concerns about the service and treatment they had received. For example, patients described difficulties accessing the gym because there were no staff trained to support patients accessing the gym. One patient expressed dissatisfaction with the way some staff treated him; however, he also said that he believed staff cared about him.

## Areas for improvement

### Action the provider MUST take to improve

- The trust must ensure that patients are fully involved in care planning.
- The trust must ensure that patients are offered the opportunity to record their preferences in an advance directive.
- The trust must ensure that patients' capacity to consent to care and treatment is formally assessed and recorded.
- The trust must ensure that second opinion approved doctors (SOADs) are requested in a timely manner.
- The trust must ensure that patients are consistently provided with HCR20V3 risk assessments and that these are reviewed and updated to reflect changes in risks.
- The trust must ensure that staff compliance with mandatory training is significantly improved.
- The trust must ensure that facilities used for the purpose of seclusion are of sufficient size to safely accommodate a resistive patient and a minimum of three staff when implementing seclusion.
- The trust must ensure that mitigating actions identified in relation to environmental and ligature risks are undertaken.
- The trust must ensure that medicines are stored at the correct, safe temperature.
- The trust must ensure that robust systems and processes are in place to support safeguarding patients. Safeguarding referrals must be made when appropriate.
- The trust must ensure that seclusion facilities are cleaned and bedding changed between uses.
- The trust must ensure that a clock is visible from the seclusion room to allow patients to independently orient themselves to time.
- The trust must ensure that patients' detention papers are appropriately filed and complete.

# Summary of findings

- The trust must ensure that there is a way of informing ward staff if temporary staff booked to work are not competent and up-to-date with 'control and restraint' training.
- The trust must ensure that gender ratios of staff are appropriate to meet the needs of patients in a timely manner.

## Action the provider SHOULD take to improve

- The trust should ensure that items not required in the secure garden are removed, and that all items within the secure garden are subject to security checks.
- The trust should ensure that training provided to staff is factually accurate.
- The trust should ensure that audit processes readily identify any deficits in patients' care records.
- The trust should ensure that patients have their medicines dispensed in a location, which upholds their privacy, dignity and confidentiality.
- The trust should ensure that information relating to the complaints procedure, PALS and the Care Quality Commission is displayed on the wards.
- The trust should ensure that all patients are provided with a physical health assessment on admission to the service.
- The trust should ensure that the seclusion and long-term segregation policy is accurate.
- The trust should ensure that all furnishings for use by patients are clean and in good condition.
- The trust should ensure that there are scheduled activities available for patients in the evenings and at weekends.

# Derbyshire Healthcare NHS Foundation Trust

## Forensic inpatient/secure wards

### Detailed findings

#### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Curzon ward	Kedleston Low Secure Unit
Scarsdale ward	Kedleston Low Secure Unit

#### Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- Staff compliance with Mental Health Act training was 100%.
- The seclusion and long-term segregation policy had been updated to reflect changes to the Mental Health Act Code of Practice (2015) but it contained inaccuracies.
- Seclusion practice did not follow the Mental Health Act Code of Practice (2015).
- Staff attached section 58 consent to treatment certificates to medicine charts. This meant that nurses knew the legal terms under which they were administering medicines.
- Staff read patients their rights under Section 132 to them on admission and every three months thereafter.
- Mental Health Act documentation was chaotically filed on the ward. We could not find any Ministry of Justice letters permitting Section 17 leave for two patients who received Section 17 leave.
- Staff completed section 17 leave paperwork correctly.
- Doctors did not request second opinion approved doctors (SOAD) in a timely manner.
- Patients could access advocacy services if they wished. However, Staff did not routinely offer this option to patients in seclusion.

# Detailed findings

## Mental Capacity Act and Deprivation of Liberty Safeguards

Training records showed that 100% of staff had undertaken Mental Capacity Act training.

No patients at the Kedleston Unit received mental capacity assessments; one patient had a T3 (section 58 consent to treatment certificate) in place regarding his medicines but

had been signed off as having capacity to consent to self-administration of medicine by a nurse without there being any assessment of his capacity to consent. There were no patients subject to deprivation of liberties safeguards (DoLS).

# Are services safe?

By safe, we mean that people are protected from abuse\* and avoidable harm

\* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

## Our findings

### Safe and clean environment

- Staff had personal electronic alarms and a set of keys allocated to them at the start of their shift. They signed to say they had these. They handed them back at the end of their shift and signed them back in to reception. Signing keys and alarms in and out meant that if any sets of keys went missing, reception staff could check who had last had them.
- Staff could maintain lines of sight relatively easily on Curzon ward, which had eight bedrooms. The nursing office overlooked the ward and afforded observation of the ward kitchen, the bedroom corridor and much of the lounge and dining room area. Lines of sight on Scarsdale ward were problematic. The nursing office did not overlook the ward and bedroom corridors were around blind corners. There were no convex mirrors to assist staff with observation of the environment. Staff positioned themselves around the ward and undertook observations of all parts of the ward.
- Managers undertook an annual assessment of ligature risks on the wards; the most recent assessment had been completed on 1 June 2016. The manager had identified a number of potential ligature risks on Curzon ward; two risks relating to bedrooms and the lounge area had been graded as extreme risks. These risks were associated with fixtures such as doorframes, a wall mounted TV and self-closing devices on internal doors. Staff mitigated these risks with observations. Managers had identified changes to the lounge area as actions on the ligature assessment but these had not been undertaken. Managers had also identified a refurbishment of the kitchen as an action, but this had not been addressed at the time of our inspection. A further six potential ligature risks had been identified relating to staff offices, therapy rooms, bathrooms and the secure garden. Four risks had no actions identified because they were either non-patient areas, or areas that patients accessed with staff supervision. Patients' access to bathrooms was individually risk assessed and identified risks were mitigated by staffs' verbal contact via the closed door, and general ward observations. Risks identified as associated with the garden such as fencing, drainpipes, a hosepipe, goal posts, air grills and a tree had no actions identified. Patients accessed the garden under the supervision of staff and staff observation mitigated the risks identified. Managers had identified a number of potential risks associated with the shared areas such as the clinic, gym and visitors' room. Staff mitigated these by staff presence and observation. Patients could only access these areas with staff supervision.
- Managers had identified a number of potential ligature risks on Scarsdale ward. These related to the ward kitchen, the lounge area, the poolroom, the quiet room and the secure garden shared with Curzon ward. Managers had identified a refurbishment of the kitchen as an action, but this had not been undertaken at the time of our inspection. Staff mitigated risks associated with other areas of the ward by staff presence and staff observations. However, a narrow band of fencing remained against the exterior wall of Curzon ward leftover from previous fencing. This presented a potential ligature risk that could be removed altogether. Ligature cutters were available in ward offices and all staff knew how to access these. Staff knew the maintenance regime for the ligature cutters.
- The secure garden area was part of the daily security checks. Staff checked the inner and outer aspects of the perimeter fences to ensure the fence was intact with no purchase for climbing. They checked that no restricted items such as illicit substances had been thrown over the fence from outside. However, there was a metal cigarette bin screwed to the concrete outside Curzon ward and since the trust had made all hospital sites non-smoking, this bin was no longer required. The bin could be kicked free from its moorings and be used as a weapon; or, it could be used to secrete restricted items. The bin was not included in the security checks. Staff had requested that estates remove the bin on two occasions but they had not done so by the time of our inspection. The garden area also contained two large bins of the sort found in public areas such as parks. These bins were large and deep but staff did not check them as part of the security checks. Patients could use these bins to secrete restricted items. There were a

## Are services safe?

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number of bait boxes for vermin in the garden area.

These contained rat poison which presented a risk of self-harm or suicide from ingestion. The bait boxes could also be used to secrete restricted items.

- There was a fully equipped clinic room in the shared space in the reception area. The clinic room was cramped and cluttered. There were two large medicine trolleys secured to the clinic room wall by way of a lock. Staff undertook daily temperature checks of the clinic room fridge. Logs showed the temperature to be consistently within safe limits. Resuscitation equipment and emergency medicines were available and logs showed staff checked them regularly. However, one small oxygen cylinder was lying on the draining board of the sink and was not stored securely. The emergency equipment was stored in a large trolley as opposed to an emergency bag. The trolley would have been cumbersome to manoeuvre through the airlocks onto either ward in the event of an emergency, therefore losing valuable time.
- Seclusion facilities were located on Curzon ward. There were two seclusion rooms housed in the same area. Staff accessed the area housing the seclusion rooms from the main corridor on Curzon ward. Staff referred to the narrow space between the two seclusion rooms as the de-escalation area. Staff told us they would take patients into this de-escalation space if they were escalating verbally and risk assessment identified the need to take the patient to a quieter, more private area to talk. The de-escalation area contained two chairs but staff told us three staff would be with the patient. With only two chairs available in this area, two people would have to remain standing. If staff were standing around during such an incident, patients could perceive it as intimidating. In addition, it would not have been possible for staff use seated restraint safely with the chairs. The patient would have had to be taken in to one of the seclusion rooms to use the seclusion room bed to implement seated restraint. The seclusion rooms were small and did not comply with the standards laid out in chapter 26 of the Mental Health Act Code of Practice. Staff could observe both seclusion room interiors easily through the glass door panels in the seclusion room doors. This meant they could observe any patient in seclusion at all times. Staff controlled/adjusted lighting and temperature via a panel in a locked cupboard. Staff stored the key for this in the nursing office on Curzon ward. However, there was no means of two-way communication. Staff, and any secluded patient, would have to raise their voices to be heard through the seclusion room door. There was no clock visible from the seclusion room to aid patients with orientation to time. Toilet and bathroom facilities were outside the seclusion rooms. This meant that staff had to take the patient out of seclusion to use the toilet or bathroom facilities. If the patient was too disturbed to leave seclusion to use these facilities, there were disposable urine bottles supplied in the seclusion room. The rooms were irregular in size, which meant that the beds were positioned diagonally across the room. There was very little space around the seclusion room beds for staff to manoeuvre patients under restraint. Staff explained the challenges in appropriately positioning a resistive patient in these small rooms without incurring injury to staff or the patient. However, we saw the building plans for the proposed new seclusion suite at the Kedleston Unit. The plans demonstrated good practice relating to the environment for seclusion. It was unclear how the unit would undertake this refurbishment without having an alternative seclusion facility to use while the building work was carried out.
- We saw housekeeping staff cleaning the wards during our inspection. Reviews of cleaning rotas showed they were up to date on both wards. Soft furnishings on Curzon ward were dirty, worn and threadbare on the arms of chairs. Fabric was torn in some places. Soft furnishings on Scarsdale ward were clean and in good condition.
- Patient led assessments of the care environment (PLACE) scores for the Kingsway site were 98.56%. This was slightly lower than the score of 99.01% for the trust as a whole; but slightly higher than the England average of 97.6%.
- Staff adhered to infection control principles including handwashing. Staff undertook an infection control audit annually and staff acted upon recommendations.
- Staff ensured that equipment was well maintained and received the appropriate safety testing.
- Managers undertook environmental risk assessments annually. Staff had identified the garden shed in the occupational therapy garden within the secure perimeter as a risk. Patients could climb up onto it and climb over the secure fence to abscond. The shed had not been removed at the time of our inspection, but all staff were aware of the risks present and were monitoring for any misuse of the shed roof.



# Are services safe?

By safe, we mean that people are protected from abuse\* and avoidable harm

## Safe staffing

- Managers calculated staffing requirements for the entire unit rather than the two separate wards. There were 48 substantive staff across the unit. Six substantive staff had left the service in the period January 2015 to January 2016. This equated to 13% of the total staff group and was higher than the trust average for care teams with greater than ten team members. Staff sickness rates in the same period were 10%, which was higher than the trust average for teams with greater than ten team members; and higher than the national average of 4.4%. Vacancy rate was -2%.
- Managers had set nursing staffing levels on Curzon and Scarsdale wards as two registered nurses and two support workers on early and late shifts (7am – 2:30pm, 2pm – 9:30pm). Staffing levels on night shifts (9pm – 7:30am) on both wards comprised one registered nurse and two support workers. The unit met these staffing levels with any shortages on shifts being due to short-notice absence. In the six months prior to our inspection, staff had reported short staffing levels to the trust using the incident reporting and recording procedure on four occasions. The manager could move staff between the two wards throughout a shift to alleviate any strain on a particular ward; for example, to facilitate Section 17 leave. The manager, who had only been in post since the end of April 2016, was actively reviewing staffing levels and shift patterns at the time of our inspection.
- Temporary staff used on the unit were mainly regular bank staff. Many of these staff were Curzon and Scarsdale wards' regular staff who also worked on the nurse bank. Occasionally, bank staff that were less familiar with the ward were used. These staff were provided with an induction to the wards to orient them. In addition, the nurse in charge ensured they were provided with guidance around security procedures. The manager could adjust staffing levels daily to take account of the needs of the patients. In the period January 2015 to January 2016, 91 shifts with staff shortages were covered with bank staff; 14 shifts in the same period could not be covered, as no temporary staff were available. When no temporary staff were available, staff would move between the two wards to support clinical activity such as section 17 leave.
- Registered nurses were visibly present in communal areas of the wards.
- Patients had regular one-to-one time with their named nurses.
- Staff rarely cancelled escorted leave and scheduled ward activities were due to too few staff.
- Staff numbers on shifts usually met set staffing levels with the use of temporary staff to cover shortages. However, there was no way for nurses in charge of the shift to know if individual bank staff were competent in the trust's five day "control and restraint" training package for the management of violence and aggression. The ward could request that bank staff were trained when booking staff from the nurse bank, but the nurse bank did not supply any information regarding the bank staff's competency in using physical interventions ("control and restraint"). Bank staff had to work 26 shifts in the trust before being eligible for mandatory training.
- There were four occasions where staff had been injured and required medical attention following violent incidents on the wards. These incidents had been recorded and reported using the trust's risk incident reporting procedure. In addition, incident reports showed an incident involving two patients fighting; they stated that bank staff on duty did not sound the alarm nor did they intervene. A colleague had sounded the alarm and staff attended the situation. The delay in responding was identified as a contributory factor in one of the patients receiving bruising to his head. The post incident de-brief identified that the bank staff had not been competent or confident in intervening. Another incident report reflected that 50% of staff on duty had been bank staff. The incident report stated that there were not sufficient staff on duty who were up-to-date with their "control and restraint" training to enable staff to respond safely to violent situations. There was no record of a safeguarding referral made regarding the patient sustaining an injury due to a delay in staff intervening.
- Staff gender ratios were not always appropriate. It was a male service but sometimes there were mostly female staff on shift. This meant that patients would have to wait until a male member of staff was available if, for example, they required a pat-down search on return from leave.
- Doctors on the ward provided medical cover from 9am to 5pm, Monday to Friday. A duty doctor provided out-of-hours cover. The duty doctor could attend the wards within an hour of being contacted by staff. Patients were

# Are services safe?

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registered with a local GP and the GP attended to their physical health needs. Patients received emergency medical treatment at the accident and emergency department at Derby Royal Infirmary.

- Staff were up-to-date with some aspects of mandatory training. The average rate of compliance with mandatory training was 85%. However;
- No doctors had attended the 'Use of Medication in the Management of Violence & Aggression' training.
- Fifty percent of staff were compliant with medication management training.
- Safeguarding adults training showed 0% staff compliance with the training.
- Fifty percent of staff were compliant with basic life support training.
- Sixty five percent of nurses were compliant with intermediate life support training; no doctors were up to date with this training.
- Fifty five percent of staff were compliant with clinical risk management training.
- Seventy three percent of staff were up to date with 'control and restraint' (violence and aggression) training.

## Assessing and managing risk to patients and staff

- The trust reported that between 1 August 2015 and 31 January 2016 there were four incidents of restraint involving four different service users; three on Curzon Ward and one on Scarsdale Ward. None of the restraints reported to the trust were considered to be prone (face down with the head turned to the side). However, we asked staff to demonstrate how they would seclude a patient and we saw that when patients were secluded, staff held them in the prone position on the seclusion room bed until all staff exited the seclusion room. Furthermore, the position the last staff in the room had to adopt could compromise the patient's breathing. It is important to ensure that there is no interference with a patient's breathing when under restraint as people can die from positional asphyxia. Section 11.2.11 of the trust 'Positive and Safe in Our Trust' policy advises staff that there should be no planned or intentional restraint of a patient in the prone position on any surface not just the floor; therefore, the technique used by staff to seclude patients was in conflict with this policy. In addition, in section 11.2.10 of the same policy advises staff that a patient should not be restrained in a way that affects the patient's airway, breathing and circulation. The technique used by staff to exit the seclusion room

following placing a patient in seclusion could potentially affect a patient's breathing. The lead trainer for the 'control and restraint' training was actively engaged with the senior managers in the trust in reviewing the training package. He recognised that it did not comply with the aspirations laid down in the Mental Health Act Code of Practice (2015), 'Positive and Safe' (DH 2014) and the national institute of health and care excellence (NICE) guideline NG10 (2015). He was enthusiastic about changing the training package. He observed that the training provided focused on the physical interventions required to physically restrain patients for 80% of the training course. Only 20% of the course was focused on alternatives to restraint such as de-escalation and identifying triggers for the behaviour. In reality, staff spend significantly more of their working time de-escalating situations than physically restraining patients, so the training focus was skewed in the wrong direction.

- The trust reported that there were three instances where staff used seclusion on Curzon Ward and no use of long-term segregation in the same period. However, we identified that the use of seclusion on Curzon and Scarsdale wards was being under-reported to the Mental Health Act (MHA) office. We spoke with the MHA lead for the trust and they told us it appeared that this had been happening since 2011. Staff had only notified them of 'exception reports' which were only reported if the episode of seclusion was of eight hours duration or more. We requested an updated data set on the use of seclusion following our inspection. The trust provided updated figures, which showed that in the period August 2015 to January 2016 there were four episodes of seclusion. Three of these involved patients on Curzon ward, and one involved a patient on Scarsdale ward. The updated figures included data relating to nine episodes of seclusion in this period, all of which involved patients on Curzon ward. To fulfil our request, the trust had had to track incident forms, which had recorded patients held in seclusion and cross-reference these with seclusion records to establish how frequently seclusion was being used at the Kedleston Unit; this demonstrates that the system in place to account for seclusion use prior to our inspection was not capturing accurate data. The reporting of the use of seclusion at the unit was inconsistent, therefore making it difficult for the trust to provide accurate figures.

## Are services safe?

By safe, we mean that people are protected from abuse\* and avoidable harm

- We reviewed eight seclusion episodes and found that the doctor had not been informed of the seclusion episode in one case; the doctor was informed when it had been terminated. In two cases the time the doctor attended had not been documented, and in a further three cases it was over two hours before the doctor attended. One patient's seclusion records were so poorly filed we struggled to review them. Patients did not have seclusion care plans, fluid and diet charts or advance statements in their seclusion records. All of these were stated as requirements in the trust seclusion policy. However, one patient had been secluded for two weeks; staff had been careful to re-integrate the patient to the ward in a graded and managed manner. This meant that the patient did not become overwhelmed by the stimulus of the general ward activity after spending such a lengthy period in seclusion.
- During our inspection, a patient was in seclusion for two days. We could not find any evidence of an independent multidisciplinary review having been undertaken. We highlighted this to ward staff who arranged for this review to take place. Staff terminated seclusion following this review.
- The policy governing the use of seclusion contained inaccuracies. Section two of the policy presents a paragraph relating to the appropriate facilities to undertake seclusion as a direct quote from the Mental Health Act Code of Practice 2015. It is not a direct quote; it has been qualified by the addition of the word "ordinarily". This meant that staff could be secluding patients in various environments without being clear about legal expectations in terms of suitable, safe environments. Section 5.1 relates to the use of seclusion with an informal patient; the fifth paragraph is presented as containing a quote from the Mental Health Act Code of Practice, section 26.106, but it is not a quote. The paragraph has been altered and the meaning has been changed. Instead of advising staff, "Seclusion should only be used in hospitals and in relation to patients detained under the Act. If an emergency situation arises involving an informal patient and, as a last resort, seclusion is necessary to prevent harm to others, then an assessment for an emergency application for detention under the Act should be undertaken immediately." (Mental Health Act Code of Practice 2015, 26.106, pp 300); the guidance advises staff "seclusion of an informal patient should be used in an emergency situation", there is an absence of emphasis on this action being the action of last resort. The trust policy also stated that a registered nurse should undertake observation of a patient in seclusion. However, we found evidence of support workers, regular and bank, undertaking observations of patients when they were in seclusion.
- We could find no evidence that staff had monitored patients' physical health following the use of rapid tranquillisation medicine; patients' care records did not contain the trust's recognised tool to guide staff in undertaking such physical observations. The tool was the Derbyshire Early Warning Score (DEWS) and was referenced in the associated policies for restraint, seclusion and rapid tranquillisation. National Institute of Health and Care Excellence (NICE) guidance states that it is essential to monitor patients' physical observations, as there is a risk of positional asphyxia, or adverse effects from rapid tranquillisation medicine.
- The trust policy on the use of medicine to manage aggression and violence considered rapid tranquillisation to be intramuscular injection of medicine. The Mental Health Act Code of Practice states that oral medicine used for the purpose of managing aggression and violence is to be considered as rapid tranquillisation (Mental Health Act Code of Practice, 26.94). No medical staff had attended the training in the use of medicines to respond to aggressive and violent behaviour.
- There was no evidence of any recent medicine errors. Staff had reported medicine errors appropriately and there was evidence of learning lessons from medicine errors. One registered nurse held the controlled drug cupboard keys and a second registered nurse held the medicine cupboard keys. This system ensured that two nurses checked and dispensed any controlled drugs. However, two nurses dispensed medicines out of a lockable medicine trolley in the communal areas of the wards. This meant that they could become distracted which could increase the likelihood for medicine errors to occur. It could also compromise patient confidentiality.
- Nursing staff undertook a risk assessment on admission using the functional analysis of the care environment (FACE) risk screening tool. Nurses regularly updated these to reflect any changes in identified risks. Staff also completed the 20-item Historical Clinical Risk

## Are services safe?

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Management, Version 3 (HCR-20V3). HCR-20V3 is a comprehensive set of professional guidelines for the assessment and management of violence risk. We found that four patients had them in place and they were up-to-date. Six patients had them from previous hospitals, but staff had not reviewed and updated them since admission to the Kedleston Unit. Seven patients had no HCR-20V3 and two patients had incomplete HCR20V3. HCR-20V3 contains extensive guidelines for the evaluation of not only the presence of 20 key violence risk factors, but also their relevance to the patient. It also contains information to help evaluators construct meaningful formulations of violence risk, future risk scenarios, appropriate risk management plans, and informative communication of risk.

- Staff used blanket restrictions only when justified based on identified risk. In March 2016, the Positive and Safe steering group in the trust had audited the use of blanket restrictions in all services in the trust. Outcomes for the Kedleston Unit were that patients no longer had a fixed bed- time enforced upon them, and staff would review restrictions relating to access to the kitchen on Curzon ward following refurbishment of the kitchen to reduce the risks present. Patients were subject to a pat-down search upon return from unescorted leave. Staff obtained consent from patients prior to undertaking searches. Patients were taken on to the ward to be searched. This meant there was a potential for risk items to be taken on to the ward. Patients' bedrooms were searched as per the random room search schedule, unless there was a reason to believe they may have risk items in their room. Staff sought consent from patients prior to undertaking room searches. If patients did not consent to personal searches or to room searches, staff were guided by the trust search policy.
- Staff compliance with safeguarding adults training was 0%. There had been two safeguarding referrals completed for patients at the Kedleston Unit in the six months prior to our inspection. One related to physical abuse and the other to organisational abuse regarding extended periods of seclusion. An incident where a patient had been injured had not been considered as a safeguarding matter but should have been. The absence of appropriately trained bank staff had been identified as a contributory factor on the associated incident reporting and recording form.

- Staff managed medicines well. Medicines reconciliation, transport, storage, disposal and dispensing practices were good. However, during our inspection, the clinic room was excessively warm for safe medicine storage and there was no access to air conditioning to cool the clinic room.
- Staff facilitated children visiting in a visitor's room separate to the wards.

### Track record on safety

- Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include 'never events' (serious patient safety incidents that are wholly preventable). The trust reported seven serious incidents in the period 1 January 2015 to 31 December 2015 for this core service. None of these were 'never events'. Four were absconsions; one was an allegation against a health professional, and two were unauthorised absences meeting the criteria for serious incidents.

### Reporting incidents and learning from when things go wrong

- Staff knew to report and record all risk incidents, and all near misses, and did this consistently.
- Staff were open and transparent and explained to patients when things went wrong. We saw an example of this regarding a confidential letter sent to the wrong address.
- Staff received feedback from investigation of incidents both internal and external to the service at monthly staff meetings, in clinical supervision and through the trust's 'blue light' system on the trust's intranet. All staff were obligated to check their emails regularly to ensure they did not miss a 'blue light' alert. Following feedback from our inspection, the trust updated staff on issues relating to seclusion use and to mental capacity assessments using the 'blue light' system.
- Staff recorded any changes to patients' care on the incident reporting and recording form and updated the relevant care plans.
- Staff recorded any debriefs for staff and patients on the incident recording and reporting form.
- Psychologists provided support and debriefs to staff following any serious incidents.

# Are services effective?

Inadequate 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

## Our findings

### Assessment of needs and planning of care

- We reviewed 19 sets of care records. Four patients had not had a physical health assessment on admission to the service. Staff thought two patients had had a physical health assessment but they could not be found during our inspection. A further 10 patients had physical health assessments on admission but they were of poor quality with little detail, and some sections in the pro forma were incomplete. Three patients had good quality physical health assessments.
- Doctors told us that patients attended the local GP for annual physical health checks. We were unable to find any evidence of this having taken place in any patients' care records or find any outcomes from these annual physical health checks.
- Occupational therapists undertook assessments using the model of human occupation screening tool (MOHOST) to inform the provision of 'meaningful activity' programmes for each individual patient.
- Patients' care plans were not personalised, holistic or recovery-oriented; we found this to be the case in all the 19 sets of care records we reviewed. One patient had a care plan that consisted of features of his diagnosis copied and pasted from the ICD10. ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). We found large numbers of care plans for each patient care plans; one patient had 14 in total. There were no summary files for these care plans. We found little evidence that patients had been involved in care planning, nor that staff offered them a copy. However, nursing staff had regularly evaluated care plans. However, Patients had wellness recovery action plans (WRAP); these were personalised and recovery-focused.
- The Mental Health Act Code of Practice (2015), national institute of health and care excellence (NICE) guidance NG10 (2015) and 'Positive and Safe' (DH 2014) all state that patients should have a positive behaviour support plan or something similar. These plans should contain primary, secondary and tertiary strategies to manage identified risks. We did not find any evidence of these plans in any patient's care records.
- Care records were in transition from paper-based files to an electronic, password-protected system. Some care

records were electronic and some were on paper. Staff stored the paper-based files in lockable cabinets in the nursing office. All regular staff had access to both sets of records. However, some bank staff did not have access to the electronic care records as they would not have a password to log on to the electronic system.

### Best practice in treatment and care

- National institute of health and care excellence (NICE) guidelines were not being followed with regards to rapid tranquilisation and subsequent physical health monitoring.
- Medicine charts were well written, clear, signed and dated. Section 58 consent to treatment certificates were attached to medicine charts. This meant that nurses would be aware of the legal basis on which they were administering medicines. However, one patient was administered medicines based on a Section 58 certificate (T3) from 2012. A T3 indicates that the patient is not capable of understanding the nature, purpose and likely effects of medicine. A nurse had recorded the patient as giving informed consent to self-administer medicines on June 2 2016. Clearly, there was conflict between these.
- Psychologists offered psychological therapies such as dialectical behaviour therapy (DBT) as recommended by the national institute of health and care excellence (NICE).
- Occupational therapists assessed patients using recognised assessment tools such as the model of human occupation screening tool (MOHOST). They then devised individualised activity schedules for patients to meet their identified needs. Staff also used a recognised rating scale called health of the nation outcome scales (HoNOS) to measure patients' progress. There was some evidence of patients making progress from the HoNOS.
- Patients' care records did not demonstrate good access to physical healthcare. Patients had been receiving physical healthcare but staff were not routinely documenting this in their care records. We saw physical health issues being fully discussed in multidisciplinary team meetings. No patients reported experiencing poor physical health care. Staff referred patients to specialist services when needed.
- Clinical staff undertook clinical audit such as care records, medicine charts and the clinic room. The audit tool used to audit the care records did not have any prompt regarding mental capacity assessments being

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undertaken by staff, or the presence of positive behaviour support plans. Neither did it prompt any focus on the quality of the documents audited. We reviewed several completed audit documents and our findings varied with the outcome of these audits. For example, the audit documents stated that documentation relating to physical health assessments on admission were completed; however, we could not find the evidence to confirm this.

## Skilled staff to deliver care

- The full range of mental health disciplines provided input to the wards. There was a consultant psychiatrist, occupational therapists, psychologists and a pharmacist. The same multidisciplinary team worked across both of the forensic wards.
- Staff were provided with an induction to the unit when they commenced employment with the trust. No support workers were engaged in the Care Certificate standards as the trust had halted its rollout of this scheme. The trust planned to re-instate the Care Certificate standards in the future.
- Staff had access to monthly team meetings. There was evidence of learning from when things go wrong in the minutes of these meetings.
- Eighty four percent of non-medical staff had had an appraisal in the 12 months prior to our inspection.
- Eighty four percent of non-medical staff were up-to-date with supervision.
- Medical staff's supervision rates were 58%, and psychology staffs' supervision rates were 56%. However, the consultant psychiatrist had had regular managerial and clinical supervision.
- Managers addressed poor staff performance as per the trust HR policy. Two staff members had been dismissed in the 12 months prior to our inspection.

## Multi-disciplinary and inter-agency team work

- Multidisciplinary team meetings took place once a week on both wards. Patients were seen in the multidisciplinary team meeting once a fortnight with half the patients seen one week and the other half seen the next. The meeting was inclusive and collaborative. Patients were fully involved and jointly completed their risk assessments with the multidisciplinary team.
- Nursing handovers were thorough and effective. Nurses handed over using the electronic care record system to

provide up-to-date, accurate information. The nurse receiving the handover documented the handover onto a handover sheet, which staff filed and kept for reference.

- Families and carers were invited to care programme approach meetings and multidisciplinary team meetings with the patient's consent.
- There was no evidence of effective working relationships with GPs.
- There was some evidence of effective working relationships with care coordinators regarding discharge of patients.
- There was no evidence of effective working relationships with the local authority safeguarding team.

## Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- Staff compliance with Mental Health Act training was 100%; they accessed this via an e-learning training package. However, staff were not clear in their understanding of the Mental Health Act, Code of Practice or the guiding principles. They were not implementing seclusion as set out in the Mental Health Act Code of Practice.
- Patients had their rights under Section 132 presented to them on admission and every three months thereafter. Staff had recorded this, as well as the patient's understanding, in the care records.
- Staff could seek administrative support and legal advice about the implementation of the Mental Health Act and its Code of Practice from a central team.
- Mental Health Act documentation was chaotically filed on the ward. It took some considerable time and effort to track down all relevant parts of the documentation. We could not find any Ministry of Justice letters permitting Section 17 leave for two patients who had Section 17 leave. We passed our concerns on to the Mental Health Liaison lead.
- Section 17 leave paperwork had been filled in correctly and was up to date.
- Doctors were not requesting second opinion approved doctors (SOAD) in a timely manner. One patient had been receiving medicine on a Section 62 since April 5 2016 with no evidence that doctors had made a SOAD referral. Medicines can be given to a patient on the authorisation of a section 62 in an emergency. It would not be expected that this would remain ongoing without being considered by a SOAD.

# Are services effective?

Inadequate 

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- Patients could access advocacy services if they wished. However, staff did not offer this facility routinely to patients in seclusion. The Mental Health Act Code of Practice states that this should be offered to patients in seclusion.

## Good practice in applying the Mental Capacity Act

- Training records showed that 100% of staff were up-to-date with Mental Capacity Act (MCA) training. However, staff did not have a good knowledge and understanding of the Mental Capacity Act. No patients had formal capacity assessments undertaken as a matter of course. Many staff believed this assessment was only a requirement in the event that the police wanted to interview the patient in connection with an offence. We spoke with the MCA lead in the trust who explained that there was a recommended MCA assessment tool on the electronic care record system, which they believed staff completed. They were unaware that staff did not complete them. We reviewed the MCA training package delivered in the trust. It was an e-learning training package, which allowed staff to skip sections of it and still achieve a pass mark. Staff told us it was too long and too difficult. The training package contained inaccuracies such as a statement regarding parental consent. The trust was reviewing this training provision following feedback from our inspectors.
- The trust had a policy on mental capacity called 'consent to examination and treatment' but staff were not using it. Staff were not assessing patients' capacity and their understanding of mental capacity assessments was that they were only required if the police wished to interview a patient in relation to an offence. No staff were aware of the existence of the functional assessment of the care environment (FACE) mental capacity assessment tool which was available on the electronic care record system until we told them of its existence.
- Staff had not undertaken any assessments of patients' mental capacity. We found evidence that a patient ought to have had an assessment of his mental capacity prior to being care planned for self-administration of medicines but had not had such an assessment.
- Audit processes on Kedleston unit failed to identify that the detention paperwork was in a poor state and that staff were not undertaking formal mental capacity assessments.
- We highlighted our findings to the trust during our inspection. Following our inspection, the trust made alternative arrangements for staff training in the Mental Capacity Act. They had informed all staff of the need to undertake mental capacity assessments and they had instituted a programme of audits to ensure that staff were undertaking mental capacity assessments for patients who required such an assessment.

# Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

## Our findings

### Kindness, dignity, respect and support

- Staff were responsive to patients' needs and they were supportive.
- Patients told us staff were kind and treated them well.
- Patient led assessment of the care environment (PLACE) scores relating to privacy, dignity and wellbeing were 94% for the Kingsway site; the trust average was 95% and the England average was 86%.

### The involvement of people in the care they receive

- Patients admitted to the wards were oriented to the ward and provided with information in the form of a booklet called "Kedleston Unit inpatient guide". The booklet contained comprehensive information relating to the ward schedule, therapies on offer and visiting arrangements.

- Patients' care records did not demonstrate patients being actively involved in care planning, nor of staff offering them a copy of their care plans. However, patients were actively involved in reviewing their risks in multidisciplinary team meetings. Patients' care records demonstrated personalised wellness and recovery action plans (WRAP).
- Patients could access advocacy services. Staff would assist with this if patients did not want to contact the service themselves.
- Families and carers were offered the opportunity to be involved in care programme approach meetings and multidisciplinary team meetings if the patient consented.
- Patients were not involved in service development. They were not involved in staff recruitment processes.
- Patients did not have advance decisions in place.



# Are services responsive to people's needs?

Good 

By responsive, we mean that services are organised so that they meet people's needs.

## Our findings

### Access and discharge

- Average bed occupancy rates for Scarsdale ward between 1 August 2015 and 31 January 2016 was 91.6%. Average bed occupancy rates for Curzon ward in the same time period was 78.5%.
- The readmissions within 90 days were provided for both wards. There was one readmission in the period 1 August 2015 and 31 January 2016, which was to Curzon Ward.
- There were six out of area placements between 1 August 2015 and 31 January 2016 relating to this core service. All patients had been discharged, leaving no out of area placements at the time of our inspection.
- Patients were not moved between wards during an admission episode unless this was justified on clinical grounds and was in the interests of the patient.
- When patients were moved or discharged, this happened at an appropriate time of day. This ensured that patients had access to all relevant formal support systems when they were moved or discharged.
- Discharge was not delayed for other than clinical reasons. There were no delayed discharges from either ward from 1 August 2015 to 31 January 2016.
- The trust provided the average length of stay for discharged and current patients from 1 February 2015 to 31 January 2016 for both wards. The average length of stay for both wards was 385 days for discharged patients and 348 days for current ones.

### The facilities promote recovery, comfort, dignity and confidentiality

- There were a full range of rooms and equipment to support treatment and care. However, the clinic room was shared by both wards and was situated in the shared space at the reception area of the unit. Because of where the clinic was situated, the risks associated with taking individual patients to the clinic room would have meant staff would be required to escort the patient; the number of staff required to escort would depend on the individual patient's risks. Staffing such escorts would significantly deplete staff available on the ward; therefore, patients did not routinely attend the clinic room despite all the examination equipment available in the room.

- Patients could access a gym at the unit. However, there were no ward-based staff trained to facilitate gym induction. A patient told us he had waited for several weeks to be inducted to the gym facilities. Managers sourced a private personal trainer to attend the unit and undertake gym inductions with the patients so that they could access the gym facilities. There were plans to send two staff members from the wards on a training course in September 2016 so that they could provide gym inductions.
- There were quiet rooms available for patients to use should they choose to do so. There was a comfortable visitors' room off the wards, in the shared space in the reception areas. Children visiting would also use this visiting room.
- Patients could make phone calls in private. Public phones were available in communal areas of the wards, but the public phone on Curzon ward was out of order at the time of our inspection. Staff allowed patients to use the wards' mobile phones to make calls in private.
- Patients could access outside space in the secure garden. Staff on Scarsdale ward and Curzon ward would negotiate with each other regarding when patients from the different wards could spend time in the garden. Staff would not allow both wards' patients outside at the same time as there had previously been aggression between the two groups when outside together.
- Patients told us the food was of a good quality and there was good choice available.
- Patients on Scarsdale ward could make drinks and snacks at any time of the day. Patients on Curzon ward could not have 24-hour access to their kitchen due to the potential ligature risks. Patients on Curzon ward were provided with a drinks trolley, which was kept in the open plan dining room. These drinks were cold drinks. Staff had to facilitate hot drinks due to the risks present in the kitchen. The kitchen was scheduled for refurbishment to reduce the risks present; this would enable staff to allow unrestricted access to the kitchen.
- Patients could personalise their bedrooms to reflect their taste and preference.
- Patients on the wards were able to store possessions securely in their bedrooms. Patients on Scarsdale ward had keys to their rooms, which meant they could access these possessions whenever they wanted. Patients on Curzon ward did not have keys to their rooms but could securely store their possessions there. They had to ask staff to unlock their rooms before they could access

# Are services responsive to people's needs?

Good 

By responsive, we mean that services are organised so that they meet people's needs.

their possessions. Patients on Curzon ward did not have their own room keys as staff had identified that some patients used the large, old-fashioned keys to self-harm. The manager was reviewing alternatives to the key access such as electronic fob access.

- Patients had individualised “meaningful activity” plans, which detailed varied activity schedules including educational as well as therapeutic and social activities. There were no structured activities available to patients in evenings and at weekends. Nursing staff would play pool, card games and board games with patients but not all patients enjoyed these activities.

## Meeting the needs of all people who use the service

- The wards were fully accessible for people with physical disabilities. Adapted bathrooms were available on both wards.
- Information leaflets about the service, about advocacy services, about the Care Quality Commission and about the complaints procedure were not readily available on the wards without asking staff. Staff could access information leaflets in languages other than English but they did not have any such leaflets to hand at the time of our inspection.
- Staff could access signers or interpreters via the trust if required.
- Patients with particular dietary requirements had their needs met; this included catering to patients with religious needs or for those from ethnic backgrounds

- Patients could access spiritual support from local faith leaders if they wished to do so. Staff could contact the faith leader and arrange for visits. However, there was no multi-faith room available within the unit.

## Listening to and learning from concerns and complaints

- In the period 1 February 2015 – 31 January 2016, three complaints were received about the forensic service. None of these complaints was upheld and none were referred to the ombudsman.
- Patients told us they knew how to complain and that they received feedback. In addition to the trust's formal complaints process, there were secure boxes on both wards where patients could post complaints, compliments or suggestions about the service. Staff would review any complaints in these boxes and decide whether they could be resolved locally or whether they required passing on to the complaints department. No patients reported any dissatisfaction with this process.
- One staff member we asked was able to tell us about the complaints process and was able to show us how to access information leaflets about the process and about the patient advice and liaison service (PALS). Other staff we asked were not aware of the information leaflets available on the trust's intranet.
- Staff received feedback about outcomes from complaints investigations in supervision and in monthly staff meetings. For trust wide issues, staff received a 'blue-light' alert sent round to all trust staff via email.
- The service received 23 compliments between 1 February 2015 and 31 January 2016.

# Are services well-led?

Inadequate 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

## Our findings

### Vision and values

- Staff could not describe or were aware of the trust's vision or values.
- Staff were unclear about what objectives the team might have. The new manager had only been in post since the end of April and had not yet identified any key objectives for the team. He had identified several objectives relating to environmental improvements to improve patients' quality of life and reduce blanket restrictions.
- Staff knew who the most senior managers in the organisation were. They told us these managers visited the service. Staff told us the area service manager was a visible presence on the wards and that she had often filled staffing vacancies and worked alongside them.

### Good governance

- Ward systems were not effective in ensuring that staff received mandatory training. Booking staff on to training was the responsibility of one of four band six nurses. This system had failed for booking staff on to the trust's violence and aggression (control and restraint) training. There was a lack of clarity regarding the availability of courses so training figures were low and not all staff were competent in this key skill.
- The trust had set supervision targets at a minimum of 10 hours supervision per year for each staff member. Nursing staff's supervision rates were 84%; medical staff's supervision rates were 58%, and psychology staffs' supervision rates were 56%. The consultant had received both management and clinical supervision regularly from appropriate personnel.
- Appraisal rates for non-medical staff were 84%.
- Managers ensured that sufficient staff usually covered shifts.
- Staff maximised shift time on direct care activities.
- Staff participated in clinical audit. However, regular care record audits had not identified the absence of physical health assessments on admission and absent or incomplete HCR20V3 risk assessments.
- Risk incidents and near misses were reported appropriately. Incident forms completed by staff demonstrated learning following risk incidents.
- No staff had completed safeguarding training.

- Training records showed that 100% of staff had completed Mental Capacity Act (MCA) training; however, mental capacity was poorly understood and assessments were not being undertaken. In addition, the MCA training package contained inaccuracies.
- Training records showed that 100% of staff were up to date with mental health act training; however, mental health act documentation was chaotically filed and difficult to find.
- The unit manager had sufficient authority. However, the manager identified a lack of administrative support as a contributory factor in an incident dated January 26 2016 relating to a breach of confidentiality. The incident had been graded as moderate.
- Staff had the ability to submit items to the trust risk register. The top risks identified on the register were ligature points identified in the annual ligature risk assessment, and the use of what was previously known as 'legal highs', but now come under the umbrella term 'psychoactive substances'.

### Leadership, morale and staff engagement

- Sickness absence rates were above the national average.
- There were no ongoing bullying and harassment cases.
- Staff knew how to use the whistle-blowing process. We received a whistle blowing from a member of staff immediately following our inspection.
- Staff told us they felt able to raise concerns without fear of victimisation.
- Staff morale was good despite the challenges. Staff were very positive about the new unit manager and believed that he would bring about positive changes to the service.
- There were few opportunities for leadership development. There were four band six nurses across the unit who were not being used to their full potential to support the unit manager. The unit manager had plans to raise their profile and get them involved in addressing some of the challenges identified by this inspection.
- Staff spoke very positively about their team. They were proud of their team and were supportive of one another.
- Staff were open and honest and explained to patients if something went wrong.
- Staff could give feedback about the service in staff meetings. They could also go directly to the unit manager who welcomed their input.

# Are services well-led?

Inadequate 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

## **Commitment to quality improvement and innovation**

- The service participated in the Quality Network for Forensic Mental Health Services.
- The service was engaged in Commissioning for Quality and Innovation (CQUIN).

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

#### Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

- Patients were not involved in care planning.
- Patients could not record their preferences in advance decisions.

This was a breach of Regulation 9 (1)(a)(b)(c)

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

#### Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

- Patients' capacity to consent to care and treatment had not been formally assessed and recorded when required.
- Second opinion-approved doctors (SOADs) were not requested in a timely manner.

This was a breach of Regulation 11 (1)(4)

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

- Patients had not been consistently provided with HCR20V3 risk assessments.
- Identified environmental risks and ligature risks had not been addressed using the actions identified on annual assessments.
- Staff training figures such as for safeguarding and 'control and restraint' were too low.

This section is primarily information for the provider

## Requirement notices

- Seclusion rooms did not meet the standards set out in the Mental Health Act Code of Practice 2015 and compromised the safety of staff and patients using them.
- Medicines were being stored at temperatures too high to support safe storage.

This was a breach of Regulation 12(1)(2)(a)(b)(c)(d)(g)

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

- Staff compliance with Safeguarding training was 0%.

This was a breach of Regulation 13 (1)(2)

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

- Seclusion rooms were not clean
- Staff could not effectively use the clinic room to see patients and dispense medicines due to its location in the unit.

This was a breach of Regulation 15 (1)(a)(f)

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

- Patients' detention papers were often chaotically filed and difficult to find in their entirety.

This was a breach of Regulation 17 (2)(b)(c)

This section is primarily information for the provider

## Requirement notices

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

- Staff training figures for key training such as safeguarding, basic life support, intermediate life support, clinical risk and 'control and restraint' was extremely low. No medical staff had attended training in the drug management of violence and aggression.
- Temporary staff were not always competent and up to date with 'control and restraint' training. This was directly linked to a patient sustaining an injury from another patient during a violent incident.
- Gender ratios of nursing staff on shifts were not always appropriate for an all-male service. This meant that patients often had to wait for a gender appropriate member of staff to have their needs met.

**This was a breach of Regulation 18 (1)(2)(a)**